Amendments to the Claims

This listing of claims will replace all prior versions and listings of claims in the application:

Listing of Claims:

Claims 1-21 (Canceled)

Claim 22 (New): In a medical insurance payment system having a plurality of medical providers and a plurality of insurance payers wherein medical reimbursement claims are submitted electronically from a practice management computer system of a respective provider to a claims processing computer system of a respective payer for payment determination, wherein an intermediary claim management system is in electronic communication between the practice management computer system of the respective provider and the claims processing computer system of the respective payer, wherein the intermediary claim management system includes a particular computer apparatus having software installed thereon, and wherein the software includes computer-executable instructions executable by the particular computer apparatus, a computer-implementable method for improving medical reimbursement claim processing between medical providers and insurance providers, comprising the steps of:

receiving a medical reimbursement claim electronically from the practice management computer system of the respective provider, the claim including data about a patient of the respective provider, a service provided to the patient by the respective provider, and the respective payer to whom the claim must be submitted for payment;

determining if the claim received from the practice management computer system of the respective provider has any one of a plurality of identifiable errors;

if the claim does not have any identifiable errors, formatting the claim into a format required by the claims processing computer system of the respective payer;

submitting the claim electronically to the claims processing computer system of the respective payer for payment determination in the format required by the claims processing computer system of the respective payer;

receiving a substantive response from the claims processing computer system of the respective payer regarding the claim;

formatting the substantive response received from the claims processing computer system of the respective payer into a standardized format, wherein the standardized format is agnostic of the respective provider; and

presenting the formatted, substantive response from the claims processing computer system of the respective payer to the respective provider to enable the respective provider to determine if further action on the claim is necessary.

Claim 23 (New): The method of claim 22, wherein the intermediary claim management system maintains a list of identifiable errors in a database accessible by the intermediary claim management system.

Claim 24 (New): The method of claim 23, wherein the list of identifiable errors is derived from one or more of (i) rules provided directly by the respective payer, (ii) rules provided by one of the plurality of insurance payers, and (iii) rules based upon prior rejections of claims previously received by the intermediary claim management system from the claims processing computer system of the respective payer.

Claim 25 (New): The method of claim 22, wherein the step of determining if the claim has any one of the plurality of identifiable errors comprises identifying if required information is missing from the claim.

Claim 26 (New): The method of claim 25, wherein the required information is mandated by the claims processing computer system of the respective payer.

Claim 27 (New): The method of claim 25, wherein the required information is mandated by rules of one or more of the plurality of insurance payers.

Claim 28 (New): The method of claim 22, wherein the step of determining if the claim has any one of the plurality of identifiable errors comprises identifying if information within the claim is internally discrepant.

Claim 29 (New): The method of claim 28, wherein information within the claim is internally discrepant if at least two pieces of information are not permitted to coexist within the claim based on a rule of the respective payer.

Claim 30 (New): The method of claim 28, wherein information within the claim is internally discrepant if at least two pieces of information are not permitted to coexist within the claim based on a rule of the plurality of insurance payers and not based on a rule specific only to the respective payer.

Claim 31 (New): The method of claim 22, further comprising the step of, if the claim has any one of the plurality of identifiable errors and before submitting the claim electronically to the claims processing computer system of the respective payer for payment determination, presenting the claim back to the respective provider for correction.

Claim 32 (New): The method of claim 31, wherein the step of presenting the claim back to the respective provider comprises flagging the one or more identifiable errors in the claim that need to be corrected.

Claim 33 (New): The method of claim 31, wherein the step of presenting the claim back to the respective provider comprises sending an email notification to the respective provider.

Claim 34 (New): The method of claim 31, wherein the step of presenting the claim back to the respective provider comprises displaying the claim with the one or more identifiable errors

to the respective provider on an interactive, web-accessible site generated and provided by the intermediary claim management system.

Claim 35 (New): The method of claim 34, further comprising the step of receiving edits to the claim from the respective provider directly within the interactive, web-accessible site.

Claim 36 (New): The method of claim 31, further comprising the step of receiving the claim electronically back from the practice management computer system of the respective provider after the respective provider has corrected the claim internally within the practice management computer system.

Claim 37 (New): The method of claim 22, wherein the substantive response received from the claims processing computer system of the respective payer includes one of a rejection of the claim, a current status of the claim, a request for additional information associated with the claim, or an approval of the claim for payment.

Claim 38 (New): The method of claim 37, wherein the rejection of the claim includes a rejection code of the respective payer.

Claim 39 (New): The method of claim 38, wherein the step of formatting the substantive response received from the claims processing computer system of the respective payer into the standardized format includes describing the rejection code in a human-understandable text format.

Claim 40 (New): The method of claim 22, further comprising presenting a status of the submitted claim to the respective provider prior to receiving the substantive response from the claims processing computer system of the respective payer.

Claim 41 (New): The method of claim 22, wherein the step of presenting the formatted response from the claims processing computer system of the respective payer to the respective provider comprises displaying the formatted response to the respective provider on an interactive, web-accessible site generated by the intermediary claim management system.

Claim 42 (New): The method of claim 22, wherein the step of presenting the formatted response from the claims processing computer system of the respective payer to the respective provider comprises sending an email notification to the respective provider.

Claim 43 (New): The method of claim 22, further comprising storing the claim in a database of the intermediary claim management system.

Claim 44 (New): The method of claim 22, further comprising displaying a report about the claim to the respective provider on an interactive, web-accessible site generated and provided by the intermediary claim management system.